

Needs of Special Populations



This section describes the needs of special populations. It describes the housing and services needs for older adults and persons with functional limitations, people who have mental health/chemical dependency issues, immigrants/refugees, sex offenders, victims of domestic violence, homeless youth and young adults, and people with HIV/AIDS and their families.

Older Adults and Persons with Functional Limitations

The proportion of the population of older adults is increasing, especially the very old. In Seattle, the number of people age 75 and older increased 5.3% between 1990 and 2000, and now makes up almost 7% of the City's total population. Many in this older age group have increasing physical, social, and psychological limitations. With the help of support services, many will be able to remain in their homes, if their homes are accessible for themselves as well as their caregivers. While home modifications are an option to "aging in place", others may need to move to some other housing arrangement such as assisted housing which also needs to be accessible and affordable.

In 2001, "approximately 33 % of senior households who are 62 years of age and older earn less than \$34,999 per year (about 60-65 % of the area's median income.)" [*An Analysis of the Senior Housing Market in Seattle, Washington*, Prepared by Novogradac & Company, LLP, for the Seattle Housing Authority.]

Given the increasing expense of housing, especially rental housing in the Seattle market, subsidies, and especially Section 8 vouchers will be required in order for older adults to continue to afford to live in our community. Unfortunately, under current reduction proposals to the Section 8 voucher program, the City of Seattle could lose as much as \$19.5 million in voucher subsidy funding by 2009. This could mean as many as almost 2000 families would no longer be assisted. [Center on Budget and Policy Priorities: *Local Effects of Proposed Cuts in Federal Housing Assistance Detailed*, Washington, March 17, 2004.]

The Seattle Housing Authority (SHA) is the primary provider of housing for low-income elderly persons. Many SHA buildings – built over 20 years ago for elderly tenants – are now home to tenants whose average age is 74 years. As these residents age in place, they increasingly need specialized support and medical services. Also, as these tenants age and their service needs increase, service managers and supports may need to be in place in order for them to remain as renters.

The trends occurring both in the demographics of the aging population as well as the resources to meet their special needs are:

- As of July 2004, there will be a further reduction in the State's nursing home "bed-to-population ratio from 45 beds per 1,000 to 40 beds per 1,000 population age 65 or older." (Dept. of Health Expedited Rule Making: WAC 246-310-010 Certificate of Need Definitions.)
- Short of nursing home beds and adult family home arrangements, seniors will need a range of non-institutional housing alternatives that provide affordable and accessible independent living arrangements, home sharing, and assisted living.
- In any of these housing developments, provision must be made for supported service components that can accommodate space for service managers arranging in home personal care and COPES (Community Options Program Entry System), which serves nursing home-eligible clients who, with appropriate community supports, can be served at home or in some other community-based living arrangement. Space will also be required for meal programs; a variety of "healthy aging" components such as exercise, both indoor and outdoor, including gardening and walking; as well as opportunities for socialization.
 - A variety of chronic disease processes flow from isolation or being "home bound". "Healthy Aging" interventions are proving to have statistically significant impacts on a variety of these chronic diseases. These interventions and provisions for the space to provide them are essential in this era of rapidly declining resources for both chronic and acute care needs.
- Provision must be made for those persons with developmental disabilities who themselves are now aging and still are being cared for by their aging parents. They and their parents will need supportive services, possibly including space for care attendants. There are rapidly declining "institutional" options for this population. The recent closure of beds at Fircrest is indicative of further trends.

- There is a significant growth in the population of grandparents caring for grandchildren. Grandparents may have to leave “senior only” housing or move from a smaller apartment to units with more bedrooms. It often means a sudden drop in their personal resources to meet this caregiving challenge. Assistance with housing voucher support will need to be available, as well as service components that meet the needs of both the aging grandparents as well as the displaced children.

Planning for the future

How is the variety of emergent needs to be addressed? How will Seattle provide housing that is affordable, accessible and will allow the aging population to age in place as well as prevent displacement of persons of any age who find themselves in need of accessible housing? How can housing be developed that meets the changing care needs of all the populations that must be served regardless of age? Planning for “inclusion” rather than “segregation” must be the norm.

All new construction and remodeling of existing housing stock, especially when it is developed using public funds, should incorporate application of the principles of Universal Design (UD). Given the anticipated growth of the 65 and older population beginning in 2011, it is more cost-efficient to plan and build and/or remodel now in anticipation of the increased need for inclusively-designed housing. These principles are not a euphemism for “accessible” design or meeting the ADA required codes but rather are principles of good design that create an enabling environment for all.

Using UD principles to design new housing would:

- Allow the future generations of older adults to age in place, since their living spaces will already be accessible and visitable.
- Create accessible housing as a matter of course rather than as the exception.
- Funding incentives for creating universally designed housing and environments should be implemented.
- Cut down on the cost of public resources required for extensive home modifications.
- Prevent housing units from being designated as set aside units that are ADA-certified units. All units are accessible and do not sit empty, waiting to be rented or purchased by a person with disabilities.

Planning and development must also address the entire built environment in order to accommodate the housing and mobility needs of all ages. Incorporating principles of “Active Living by Design” into housing and community development projects will help us build a healthy community.

People with Developmental Disabilities

In January 2004, 7,990 persons in King County, 4,075 adults and 3,915 children, were enrolled with the Washington State Department of Social and Health Services Division of Developmental Disabilities (DDD) due to mental retardation, cerebral palsy, autism, epilepsy, or other neurological impairments. The number of persons served by DDD is increasing at an annual rate of six percent.

The majority of adults with Developmental Disabilities (DD) living in King County have extremely low incomes from employment and/or Supplemental Security Income ("SSI"). Some families with children with DD also have extremely low incomes, which is often due to the additional care needs of their disabled children.

Adults with Developmental Disabilities

The King County Developmental Disabilities Division (DDD) has a caseload of 4,075 adults. 1,387 live in Seattle and 2,688 live in King County outside Seattle.

According to the 2004-05 King County DDD Housing Plan, 1,468 adults with DD living in King County receive residential services in housing. Four hundred of these persons live in private market housing and pay more than 50% of their income for rent and utilities. Forty-three of these 400 persons live in Seattle.

In addition there are 2,340 adults on the DDD caseload in King County who do not receive residential services, many of whom have need for affordable housing. These individuals live with family members or guardians, or independently in the community. Many of these adults are living with aging parents who can no longer provide the care necessary to support their adult children with disabilities. These individuals can live successfully in the community with support systems that are appropriate to their needs, which can include a combination of case management, family, friends, or paid support providers.

In addition, there are currently 217 people with DD living at Fircrest Institution in Shoreline. The Washington State legislature mandated the downsizing of Fircrest during the 2003-05 state biennium, and will likely mandate its closure during the 2005-07 biennium. DDD estimates that approximately 115 people who are currently living at Fircrest will need affordable housing in the community in Seattle and King County between now and 2007.

In the Office of Housing's portfolio, there are 70 permanent housing units in scattered sites for persons with developmental disabilities. The majority of these units are in single family homes. Forty-three (43) of these units are dedicated for formerly homeless persons.

The King County Housing Access and Services program (HASP) has issued 300 vouchers since the year 2000 to adults with DD in King County, and continues to issue vouchers each month. In 2002, the Seattle Housing Authority issued 60 vouchers, through its special voucher program to persons with DD, but has not issued any additional vouchers since then.

Families with Children with Developmental Disabilities

Of the 3,915 children on the DDD caseload, 1,251 live in Seattle and 2,664 live in King County outside Seattle.

The housing need of families with children with DD has yet to be effectively documented. Although the majority of the DD-related units in the Office of Housing's portfolio are for single adults, there are seven units for families with children who have developmental disabilities. DDD notes that many of these children will need affordable or subsidized housing as they reach adulthood. DDD is currently developing a waiting list of families who are homeless or in need of affordable housing in order to begin to document this need.

Dual Diagnosis - Persons with Mental Illness and Developmental Disabilities

In 2003, the King County Regional Support Network provided services to 2,393 persons who had a dual diagnosis of mental illness and a developmental disability; 203 or 8% of these persons were homeless in 2003. This number likely includes some duplicated counts of persons with DD served in the DESC shelter.

Homelessness among Persons with Developmental Disabilities

The Downtown Emergency Service Center (DESC) in Seattle provided shelter to 95 persons with DD in 2002 and 77 persons with DD in 2003.

In 2003, The ARC of King County served 25 persons with DD who were at risk of homelessness through its Survival Services Program, which included ongoing case management and housing stabilization assistance.

The Seattle-King County Coalition for the Homeless Families Committee reports serving increased numbers of families with DD parents and families with children with DD in King County shelter and transitional housing programs. According to the 2003 One Night Count conducted by the Coalition, 59 individuals in shelters and transitional housing programs were reported to have a developmental disability. Because many of these programs are not staffed to provide services to meet the unique needs of these families, they face additional challenges to overcoming homelessness.

People with Mental Illness and/or Substance Abuse Disorders

Data shows that homeless people with mental illness and/or substance abuse disorders living in King County congregate primarily in Seattle's downtown core. Evidence includes the following:

- The 2003 One Night Count found 1,899 homeless individuals actually living on the streets in King County. Of those 1,728 (91%) were in the downtown Seattle area. In addition, 78% of the homeless persons in shelters or transitional housing on that night were in Seattle.
- According to the One Night Count survey, the most frequently cited disabilities among people who are homeless are mental health and chemical dependency. 50% of those who responded indicated that they had problems with substance abuse, mental health or both.¹
- The King County Crisis Clinic's Information Line reports that in 2003 they received 14,963 calls from individuals who identified themselves as being homeless. 4,539 (66%) out of the 6,844 callers who gave geographic information were from Seattle.²
- Sixteen percent (4,322) of the individuals receiving services from the publicly funded mental health Regional Support Network were homeless at some point during 2002.³ More than 30% (1,222) of the individuals served at King County's behavioral health crisis triage center during 2002 reported being currently homeless.⁴
- An estimated 28,650 low-income adults in King County are chemically dependent and in need of treatment in any given year. Between 12,000 and 18,750 of these individuals are both mentally ill and chemically dependent, yet fewer than 10% of these individuals receive the mix of services they require to promote stabilization and recovery. Data from the Seattle/King County Health Care for the Homeless Network (HCHN) indicates that 22% of their clients need chemical dependency treatment.

Despite access to the resources described above and local successes in expanding the array of housing and support service resources dedicated to serving homeless populations, HCHN and the one night count continue to document a steadily increasing population of chronically homeless adults in the Seattle area. There remains a significant gap in housing stock for the chronically homeless population, and insufficient capacity in the treatment service system to absorb those individuals not yet linked to mainstream entitlements that often present the most significant service needs. The Seattle/King County's 2002 Continuum of Care planning process identified an unmet need/housing gap of almost 2,500 shelter beds and housing units.⁵ The absence of the service intensities required to successfully house chronically homeless adults creates yet another barrier to accessing the limited housing that does exist. Without such service supports, many of the

¹ Seattle-King County Coalition for the Homeless, "The 2003 Annual One Night Count of people who are homeless in King County, WA, March 2004"

² Committee to End Homelessness King County, 2004, www.cehkc.org/hikc-scope.shtml

³ Data provided from the King County Mental Health Information System, 2002

⁴ Data provided by the Harborview Medical Center Crisis Triage Unit, 2002

⁵ Seattle/King County Continuum of Care Narrative, 2002, page 13

individuals who are chronically homeless either remain unable to access existing housing or experience ongoing or cyclical episodes of homelessness.⁶

Models for Addressing Need

Individuals who are chronically homeless present a particularly challenging set of housing, service and treatment needs as they struggle with a range of illnesses and disabilities that present great difficulties with regard to personal stability, accomplishing basic tasks of daily living, and accessing and maintaining safe, decent and affordable housing. Recent research has made clear that the provision of supportive housing, combined with appropriate treatment and supports, can help to provide a foundation upon which individuals with histories of chronic homelessness can begin the journey into recovery and attain the personal stability that is essential to regaining control over one's life. In addition, it is known that the provision of housing, by itself, or the delivery of intensive supportive services in isolation from housing are both insufficient to promote stability over time for most individuals struggling with homelessness, mental illness, and co-occurring disorders such as substance use disorders, developmental disabilities, and HIV/AIDS or other chronic health problems.⁷

The U.S. Interagency Council on Homelessness identifies Housing First strategies as one of the "new technologies that exist to move chronically homeless people off the streets and keep them housed." The approach entails moving chronically homeless people as quickly as possible into long-term housing and applying adequate service and treatment supports to allow them to succeed there. It is a different approach than those requiring homeless persons to reach stability prior to gaining access to housing.

Significant cost savings can be realized through this model. A recent research study in New York City collected data on 4,679 homeless people with severe mental disorders placed in supportive housing and compared their service use patterns to system utilization prior to housing placement. The study demonstrated that expenses related to shelters, public and state hospitals, Medicaid funded services, VA services, and state and local prisons and jails could be significantly reduced when supportive housing was provided. Prior to placement the average cost per person per year across all systems was \$40,449; post-placement this cost was reduced to \$17,277 – an estimated total savings of \$16,282 per person per year.⁸

With experience gained from a range of programs that work to house populations experiencing chronic homelessness, Seattle/King County communities have developed a strong track record in demonstrating the impact of housing linked with supportive services in reducing chronic homelessness. Housing funded by federal, state and local funds such as McKinney, HOPWA,

⁶ As part of ongoing efforts to address this issue, Seattle/King County have applied for funding under the auspices of the Corporation for Supportive Housing's Taking Health Care Home initiative to increase systems integration activities that can enhance supportive housing resources.

⁷ See, for example, Culhane, D.P., Metraux, S., Hadley, T., (2001) The New York/New York Agreement Cost Study: The Impact of Supportive Housing on Services Use for Homeless Mentally Ill Individuals (New York: Corporation for Supportive Housing) and Tsemberis, S., and Eisenberg, R.F., (2000) "Pathways to Housing: Supportive Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities." *Psychiatric Services*, 51(4): 487-493.

⁸ Culhane, D.P. and Metraux, S. "The Impact of Supportive Housing for Homeless People with Severe Mental Illness on the Utilization of the Public Health, Corrections and Emergency Shelters System: The New York-New York Initiative". Center for Mental Health Policy and Services Research, May 2001.

CDBG and HOME, Transitional Housing Operating and Rent (THOR), the Washington State Housing Trust Fund, etc., and services funded by Medicaid, Mental Health and Chemical Dependency Block Grants, HRSA/HCH and demonstration programs such as the 5-year ACCESS Project have historically been successfully braided into supportive housing initiatives specifically targeting chronically homeless individuals. Examples of such programs include Seattle's two Safe Haven facilities for persons with severe mental illnesses and co-occurring substance use disorders (Harbor House and the Kerner-Scott House), transitional and permanent supported housing for chronic public inebriates (e.g., the Wintonia and Westlake projects) and persons with mental illness (e.g., the Union and Morrison Hotels) and specialized service-enriched housing targeting individuals living with HIV/AIDS who have histories of homelessness, mental illness and substance use disorders, (e.g., the Lyon Building).

Service Delivery System

King County. The King County Department of Community and Human Services (DCHS) Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) has the primary responsibility for the service delivery system. Services include individual, family and group therapy, case management, emergency/crisis intervention, medication management, vocational assistance and training, and assistance with housing and other supports. MHCADS is responsible for assuring that the needs of project clients are met as they transition to mainstream mental health services and/or substance abuse services.

MHCADSD has as its stated mission the following, "To improve the quality of life in King County by providing services and supports to individuals, families and communities affected by mental illness and/or substance abuse or chemical dependence." MHCADSD's core values include the following priorities:

- To offer outreach, engagement and specialized services which address the unique needs of underserved populations, including ethnic and sexual minorities, persons with disabilities, persons who are homeless and individuals in late-stage illness.
- To ensure clients have access to a continuum of services and housing, including integrated services for clients with multiple needs.
- To provide services to individuals and families that are informed by research, evidence-based practice guidelines and nationally recognized standards of care.
- To encourage the provision of services that are designed in collaboration with the individual, are clinically and culturally appropriate and attempt to meet the array of supports needed for a person to achieve the highest possible quality of life while residing in an appropriate setting.

City of Seattle. The City of Seattle Office of Housing has a number of priorities concerning the development of rental housing for persons at or below 30% median income as well as service-enriched housing for persons that are homeless and/or disabled.

With the recent implementation of a new initiative called Taking Health Care Home funded by the Robert Wood Johnson Foundation and Gates Foundation, with oversight by the Corporation for

Supportive Housing, the Office of Housing is leading strategic planning efforts to support the development of permanent supportive housing for persons that are chronically homeless and disabled. This initiative is in partnership with AIDS Housing of Washington and King County Mental Health and Chemical Dependency Services Division and will seek to create over 260 units of permanent supportive housing in the Seattle/King County area over the next two years. The Office of Housing is committed to creating housing that will serve the population described in this project to support them to obtain and sustain permanent supportive housing in a “Housing First” approach.

State of Washington. In April 2004, leadership from throughout Washington State formed the Washington State Policy Academy on Chronic Homelessness. This group includes strong representation from King County, including leadership from King County MHCADSD and the City of Seattle. One of the priorities listed in their plan is to “make the case for increasing the priority to serve individuals who are chronically homeless.” The plan also calls for enhancing the linkages between services for this population and housing.

In August 2004, the U.S. Health & Human Services Department announced grant funding for substance abuse treatment. The state of Washington was awarded \$7.6 million per year for each of three years, for a total of approximately \$22.8 million. The state plans to utilize its Access to Recovery grant to provide clinical drug and alcohol treatment and recovery services to low-income individuals in crisis who are involved with Child Protective Services, shelters and supported housing, medical clinics, and community detoxification programs. The program will offer a full range of treatment services and increase the number of providers trained and qualified to offer recovery services.

King County Committee to End Homelessness (CEH). The CEH brings together key community and government leaders to establish priorities designed to move our community toward ending homelessness in the next ten years. The CEH plan calls for “linking mainstream systems such as housing, employment, mental health, education, chemical dependency, and criminal justice to services for homeless persons.”

Other Partnering Agencies. Within the King County mental health and substance abuse treatment network, the *Downtown Emergency Services Center (DESC)* is the only agency that has as its primary focus services to the chronically homeless adult population. Founded in 1979, DESC offers two main sets of services: their Clinical Program provides state-licensed mental health and substance abuse treatment and their Housing Program implements a residential continuum including emergency shelters and transitional and permanent supportive housing. In 2002, DESC’s emergency shelters served over 9,000 unduplicated people; clinical programs served over 800; and transitional and permanent housing projects served over 400.

DESC’s ability to house persons with serious mental illness and substance abuse disorders is greatly enhanced by having licensed mental health and chemical dependency treatment services within the same organizational structure. The DESC Clinical Program has provided state-licensed mental health services since 1980, and now provides homeless persons with mental illness and chemical dependency disorders with comprehensive care that includes street outreach and engagement, case management, short-term and long-term care, and chemical dependency services.

From 1994 to 1999, DESC was a participant in ACCESS, a five-year national demonstration project funded by the Department of Health and Human Services through the Substance Abuse and Mental Health Service Administration. After the ACCESS project ended, DESC was selected to be the sole vendor of mental health outreach and engagement services countywide through the Homeless Outreach, Stabilization and Treatment (HOST) project funded by King County.

Outreach and engagement specialists of DESC's HOST project target unsheltered individuals who are typically chronically homeless and have a severe and persistent mental illness or co-occurring disorder. While some clients are approached directly while on the street, engagement for others is initiated by a referral to DESC from concerned citizens, jails, Washington State Department of Health and Human Services (DSHS), the mental health court, hospitals, the Harborview Medical Crisis Triage Unit, public libraries, family members, and other mental health professionals, shelters, and drop-in centers. HOST staff connect people to other DESC services, including the day center, emergency center, safe haven, and intensive case management services. Or, depending on an assessment of the client's need, a referral is made to a more appropriate provider.

DESC began providing supportive housing in 1994, and now provides an array of housing project types for homeless single adults with disabling conditions, primarily severe and persistent mental illness and substance use disorders. DESC operates the Morrison Hotel (205 units), the Union Hotel (52 units), the Lyon Building (64 units), and the Kerner-Scott House (25 safe haven beds and 15 permanent units). In addition to these specific housing projects totaling 361 units, DESC utilizes 75 Shelter Plus Care subsidies for persons with mental illness and 55 Section 8 set-aside vouchers for persons with disabilities.

Established in 1985, the *Seattle-King County Health Care for the Homeless Network (HCHN)* program evolved into its present administrative structure whereby Public Health – Seattle & King County acts as the federal health center grantee under the Health resources and Services Administration (HRSA) – Bureau of Primary Health Care. Services are provided in numerous health department clinics, community-based agencies, and Harborview Medical Center's Pioneer Square Clinic, whereby Public Health – Seattle & King County subcontracts HRSA grant funds to 12 community partners to deliver care to homeless people in a variety of community sites such as shelters and day centers. HCHN also funds the 22-bed Medical Respite Program, operated by Pioneer Square Clinic, which serves high numbers of chronically homeless with disabling conditions.

The *Pioneer Square Clinic of Harborview Medical Center* provides primary health care and treats acute problems for adult patients residing in the downtown Seattle area. This neighborhood clinic has been in operation for over 20 years. The clinic specializes in services for homeless and low-income residents of the downtown community. The clinic staff includes physicians, nurses, psychiatrists, mental health practitioners and social workers. The clinic is an outpatient site of Harborview Medical Center and the full services of University of Washington Medicine are available for specialty services or hospitalization.

The *Mental Health Chaplaincy* is an outreach and engagement program for the most difficult and most vulnerable mentally ill street homeless people. The program uses a four-phase model to working with homeless individuals—approach, companionship, partnership, and mutuality—in

order to build and share a relationship with clients. In practice, outreach workers spend time with homeless people on the street, becoming part of their everyday experience, becoming familiar to them, and offering companionship. The *Mental Health Chaplaincy* works with Harborview Mental Health, local emergency rooms, Downtown Emergency Service Center, and the Health Care for the Homeless Network.

Evergreen Treatment Center's REACH Project targets homeless chronic public inebriates and other drug abusers. REACH staff receive referrals from the Dutch Shisler Sobering Center, where they are co-located, or conduct outreach on the street. Eight case managers with caseloads of about 20 people each work with these individuals to link them to support services and move them into appropriate housing. REACH case managers facilitate applications to the state's publicly subsidized chemical dependency treatment program (Alcohol Drug Abuse Treatment and Support Act) and other mainstream services, and they make placements in various housing programs for their clients.

Pathways Home, a McKinney-funded services only project, promotes housing stability for homeless families experiencing serious, multiple barriers to care by partnering with parents to provide family-centered, child-focused health and behavioral health services. The services include: outreach and engagement services, case management, nursing care, primary medical care, psychiatric care, mental health and substance abuse counseling services, assistance with securing permanent housing, and securing linkages with mainstream, community-based services. *Pathways Home* identifies homeless families by referrals from other programs and the Seattle Police Department's Community Service Officers, and from staff visits to clinics, day centers, and shelters. Though not as common, some families are self-referrals as a result of hearing about the program from another homeless family.

Additionally, *Pathways Home* staff visit families self-paying in hotels and motels to try to engage them in the Continuum of Care system. Each family is evaluated for their income sources, healthcare coverage, and use of mainstream services in addition to their specific housing, social and health needs. For those clients who are eligible for services by not utilizing them, the team will support the application process for the client in whatever form necessary. This ranges from providing transportation to an appointment to accompaniment and completion of forms for those who lack the capacity to do so. Case managers serve as advocates for the clients during the application process and monitor it closely.

Youth and Young Adults

Definition of a Homeless Youth or Young Adult

Homeless youth services in Seattle are intended to serve young people between the ages of 12 and 24 who are without a safe, stable place to sleep and not living as part of a family with a responsible parent figure. Homeless youth under age 18 who are served in homeless youth programs most often have experienced multiple failures of foster home placements. Young adults come to homelessness under a variety of circumstances. They generally have experienced significant trauma and disruption in normal developmental processes, resulting in a lack of basic life skill competencies, and frequently appear to experience failures in programs⁹. An estimated 820 youth and young adults are homeless in Seattle at any one time.

The Number of Homeless Youth and Young Adults in Seattle

This point-in-time estimate is based on data collected from shelter/housing programs, case management and drop in day-center service providers. This data has been updated through phone surveys of providers during 2003. During this period, 976 youth were reported in service at any one time. Adjusted for duplication, an estimated 820 homeless youth and young adults were in service. This number is used in Seattle as the most accurate point in time count of homeless youth and young adults, because it includes more sources of information than the One Night Count. The One Night Count is used in our McKinney application and in the Nature and Extent of Homelessness section of this document because it includes data on all homeless populations including youth. The One Night Count in 2003 counted 42 youth, 186 young adults, 13 minor youth with children, and 105 young adults with children in Seattle shelter and transitional housing programs, plus 51 minors alone on the street and 67 young adults living in squats, for a total of 464 youth and young adults homeless in Seattle on that night. The difference between the One Night Count and the estimate of 820 is due to the fact that in the One Night Count, young adults on the street were not counted separately from older adults (total 1,677) and youth and young adults not visible on the streets, but using drop-in or case management services were not counted.

Demographic Data on Homeless Youth and Youth Adults

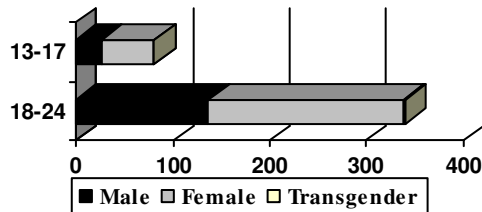
Two sources of unduplicated demographic data on homeless youth and young adults exist. While these do not represent a complete, unduplicated count of all homeless youth in Seattle, they do provide valuable information about the demographics, challenges and needs portrayed by Seattle's homeless youth population. The first is Health Care for the Homeless Network (HCHN), which provides health services to homeless people in several community clinics. In 2003, 427¹⁰ homeless youth who were living on their own (not as part of a family) were seen in Health Care for the Homeless clinics. The other source of data is the PRO-Youth program, which provides case management services to homeless youth throughout King County. In 2003, 428 new youth were

⁹ Boyer, D. (undated). Developmental Checklist for High Risk Youth. *Juvenile Justice Technical Assistance Project*. Everett, WA: Snohomish County Human Services Office of Children's Affairs.

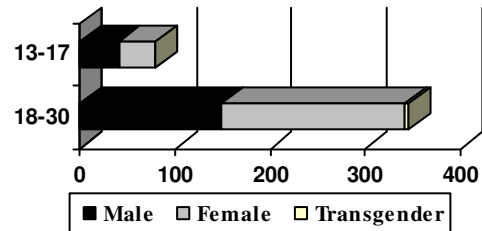
¹⁰ The source of this data is a special data query produced by Seattle-King County Department of Public Health. A slightly different total number of youth appeared in the Health Care for the Homeless 2003 annual data report. That figure appears in the Nature and Extent of Homelessness.

enrolled in services by PRO-Youth case managers. The amount of duplication between the two sources is unknown. The following demographic data were collected for these youth and young adults from these two sources.¹¹

Age/Gender of Youth Using Healthcare for the Homeless Services (Total 427)



Age and Gender of Youth using PRO-Youth Services (total 428)



Prior Living Situation of the Homeless Youth, Young Adult Population				
	HCHN		PRO-Youth	
Location	Number	Percent	Number	Percent
Non-housing (street, park, car, bus station, etc.)	35	8%	127	30%
Emergency shelter	57	13%	96	22%
Transitional housing for homeless persons	40	9%	10	2%
Psychiatric facility	0	0%	0	0%
Substance abuse treatment facility	5	1%	0	0%
Hospital	2	0.5%	0	0%
Jail/prison	10	2%	1	0.2%
Domestic violence situation	0	0%	7	2%
Living with relatives/friends	41	10%	114	27%
Rental housing	0	0%	14	3%
Other/Unknown/info missing	0	0%	59	14%
Total	427	100%	428	100%

Race and Ethnicity of the Homeless Youth, Young Adult Population				
	HCHN		PRO-Youth	
Ethnicity	Total	Percent	Total	Percent
Hispanic or Latino	20	5%	36	8%
Non-Hispanic or Non-Latino	407	95%	392	92%
Total	427	100%	428	100%
Race	Total	Percent	Total	Percent
American Indian/Alaskan Native	30	7%	14	4%
Asian	7	2%	15	4%
Black/African American	64	15%	108	27%
Native Hawaiian/Other Pacific Islander	2	0%	2	1%
White	266	62%	178	45%
Other/Multi-Racial/unknown	58	14%	111	26%
Total	427	100%	428	100%

¹¹ Seventy-five percent of the youth in this demographic category give the City as their last address. This program is funded by McKinney and City General Fund and serves Seattle and King County youth.

Special Needs of the Homeless Youth, Young Adult Population¹²		
Type	HCHN	PRO-Youth
Mental illness	224	46
Alcohol abuse	*	74
Drug abuse	*	89
Chemical/Alcohol Abuse/Dependence	88	*
HIV/AIDS and related diseases	*	5
STD/HIV/AIDS	59	*
Developmental disability	12	4
Physical disability	0	8
Abuse Issues	37	*
Domestic violence	*	22
Total¹³	420	248

*Each Data System collected data in slightly different categories

Causes and Effects of Homelessness Among Youth and Youth Adults

Most studies conducted on issues of youth homelessness include data on the family history profile of the youth. All document strong associations between negative childhood experiences and homelessness¹⁴, and high incidences of abuse, neglect, sexual abuse, parental substance abuse, and other family disorganization¹⁵.

While youth often leave unpleasant and hazardous circumstances for the street, once there, risks increase, and prospects for a successful future diminish rapidly. The lifestyle of youth on the street is “characterized by violence and deprivation – physical and sexual abuse, sexually transmitted diseases, unintended pregnancies, substance abuse and mental disorders.”¹⁶ Victimization rates on the street are very high, along with difficulty in meeting basic needs, risky sexual behavior, drug and

¹² Healthcare for the Homeless special needs data is based on health problems identified during clinic encounters. PRO-Youth special needs data is based on needs identified at initial contact – considered highly under reported.

¹³ Each youth may report no special needs or multiple needs. Therefore total needs will not match total number of youth served.

¹⁴ Burt, M. R. (1998). Demographics and Geography: Estimating Needs. *National Symposium on Homelessness Research: What Works?* Washington, DC, October.

¹⁵ De Rosa CJ; Montgomery SB; Kipke MD; Iverson E; Ma JL; Unger JB. (1999). Service utilization among homeless and runaway youth in Los Angeles, California: Rates and reasons. *Journal of Adolescent Health* 24(3), 190-200.

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Kufeldt, K., Durieux, M. & Nimmo, M. (1992). Providing Shelter for Street Youth: Are We Reaching Those in Need? *Child Abuse and Neglect*, 16, 187-199.

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Ringwalt, C. L., Greene, J. M., Robertson, M. (1998a). Risk Behaviors, Negative Familial Experiences, and Institutional Placements Among Throwaway Youth. *Journal of Adolescence*, 21: 241-252.

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Whitbeck, L. B. & Hoyt, D.R. (1999). Nowhere to Grow, Homeless and Runaway Adolescents and Their Families. New York: Walter de Grueter, Inc

Greene, J.M. (1995). Youth with Runaway, Throwaway, and Homeless Experiences: Prevalence, Drug Use, and Other At-Risk Behaviors, Volume I (Report); and Volume II (Appendixes). Silver Spring, MD: National Clearinghouse on Families & Youth.

¹⁶ Interfaith Task Force on Homelessness & Real Change/First Things First (2003). A Walk Through the Revolving Door of Homelessness in King County. Preliminary Findings, Impacts, Opportunities, and Recommendations. Seattle, WA.

alcohol abuse, criminal behavior,¹⁷ infectious diseases, and depression and suicide. Youth are regularly subjected to extreme stress and trauma while living on the street.

Several national studies also document the fact that a large proportion of homeless youth are on the run from government placements or are former foster children.¹⁸ In Seattle, the Washington State Department of Social and Health Services reported 52 youth on the run from placement in Region 4 (King County) on February 4, 2002. Even more homeless youth in Seattle are estimated to be on the run from foster care, because they come here from other regions.

Service Needs of Youth and Young Adults in Seattle

Youth have different needs relative to their status as minors or adults and relative to their developmental stages, special needs, and street experience. The service approach needs to be different for youth under age 18, especially if they have been on the street for a relatively short time. In these cases a priority is placed on minimizing the youth's exposure to the street. Residential services and support for returning to family or foster care are the first choice. However some youth, even at a very young age, are not able to engage in or be successful in foster care or residential programs, most often because of mental health or chemical dependency issues. These youth need intensive case management, advocacy to help them obtain needed services, and support for maintaining health and safety until they are stabilized or mature enough to successfully engage in transitional services.

Young adults present a range of needs. Many are developmentally ready to succeed in transitional services, but face eligibility challenges because of a criminal history, lack of identification, lack of awareness of resources, or age. Others have severe mental health issues and chemical addictions that prevent them from meeting the requirements of most programs. Another group of young adults have less obvious mental health challenges, but are not developmentally prepared to take on the challenges of responsible independent adulthood. Outreach, information and referral services, and case management assist the entire range of youth in taking whatever the next step may be for each of them toward stable housing. Many youth are fearful of services, and very minimal contact by outreach workers with provision of basic needs like food and hygiene supplies is the first step in engagement. Others need intensive support for accessing services to meet multiple needs, while many require help with completing their education, gaining job readiness and independent living skills to work toward independent housing.

A comprehensive continuum of services is needed to meet the diverse needs of youth and young adults. Outreach, case management, shelter and transitional housing services are the services required by most youth in both age groups. The majority of these young people also require one or more supportive services such as mental health counseling, chemical dependency treatment, specialized educational support services, and employment services. With the appropriate mix of services, nearly all homeless youth and young adults can successfully move out of the homeless assistance system, many into successful independence, others into mainstream social service

¹⁷ Robertson, MJ & Toro, PA. (1998). Homeless Youth: Research, Intervention, and Policy. The 1998 Symposium on Homelessness Research. Retrieved September 30, 2001, from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) of the U.S. Department of Health and Human Services on the World Wide Web: <http://aspe.hhs.gov/progsys/homeless/symposium/3-Youth.htm>

¹⁸ Paradise, E. & Horowitz, R. (1994). Runaway and Homeless Youth: A Survey of State Law. Washington, DC: American Bar Association Center on Children and the Law.

systems. Besides supporting the service continuum, efforts to close the door to homelessness by working with mainstream systems – child welfare/foster care, treatment, juvenile justice) through discharge planning and transitional services must be part of the overall plan to end homelessness.

Housing Needs of Youth and Young Adults in Seattle

Homeless youth and young adults often require substantial preparation prior to being able to enter transitional or permanent housing. Issues related to the high degree of trauma, disorganization and arrested development highlighted above along with substance abuse, mental health, sexual orientation, cultural identity, developmental disabilities and criminal history are major barriers to housing stability that transitional housing programs are presented with among the youth who apply for service. Currently most transitional housing programs for youth and young adults are designed to meet the developmental needs and skill deficits common among homeless young people, but few are able to work with youth who are chemically dependent, mentally ill, or unable to successfully work at a paying job or attend school.

In a 2000 survey of homeless youth service providers, workers who referred youth to shelter and transitional housing said the most common barriers to youth entering a program were that the maximum length of stay allowed was too short to be useful to the youth and that youth were denied service because of a criminal history or drug use. In addition, transitional housing programs are unable to accept pregnant youth due to liability insurance issues. Housing providers said that the most common reason for turning away youth was that their programs were not designed for the issues presented by the youth being referred¹⁹. Providers, committed to providing a safe environment for all residents, are forced to bar or evict the most needy and challenging youth due to substance abuse or behaviors resulting from mental health issues, without the ability to refer these youth to alternative, safe housing situations.

PRO-Youth case managers report that the geographic location of services is a barrier to many of these youth, especially young women of color²⁰. The PRO-Youth case management team has identified the need for transitional housing in more communities in Seattle. Currently, the majority of transitional housing is north of downtown Seattle, in the U-District, Sand Point, and Greenwood. Youth struggling with housing in other neighborhoods are often reluctant to go someplace unfamiliar or culturally uncomfortable and will remain near “home”, couch surfing and relying on predatory adults. Pregnant and parenting girls and young women are particularly reluctant to move to unfamiliar neighborhoods for housing.

By state licensing rules, youth under age 18 must be housed separately from those over 18. Under some circumstances appropriate separation can be licensed within the same building. Licensing considerations provide a higher level of complexity and expense in programming for minor youth, however many of the standards imposed by licensing are based on the specific needs of young people which are present in the young adult population as well. For all of these reasons, there is a need for a range of specialized services connected to transitional housing as well as services to prepare youth to enter housing and utilize it successfully.

19 Meyers, R. & Shaw, M.E. (2000) *It Takes More than Shelter: Vacancies in residential programs for homeless youth*. Seattle, WA: Seattle-King County Coalition for the Homeless Youth and Young Adult Committee and City of Seattle Human Services Department, Division of Family and Youth Services.

20 PRO-Youth Case Management Team (2004). Information from discussions at monthly County-wide case management team meetings. Seattle, WA

Mental Health Service Needs of Youth and Young Adults in Seattle

Histories of trauma experienced by troubled youth and young adults translate into significant needs for mental health services. The 2000 service gaps analysis estimated that 160 youth at any one time might seek mental health services if available. Currently, one community clinic has a part time psychiatrist who assists with medication prescription and management for mentally ill youth. One additional mental health specialist will provide services to homeless youth in the coming year as a result of a new grant. Access to most other mental health services requires enrollment in medical assistance. This poses a significant barrier to homeless youth, who have difficulty meeting the documentation requirements. The gap for mental health services is approximately 115 youth²¹. In the absence of easily accessible mental health services, advocacy is required by other providers working with youth to connect them with resources and assist them in managing their lives with minimal services.

Chemical Dependency Treatment Needs of Youth and Young Adults in Seattle

A large percentage of homeless youth are affected by drugs and alcohol, as indicated in a local Seattle study²². In 2003, 38% of youth enrolled in PRO-Youth were identified as in need of chemical dependency services. There is currently only one Chemical Dependency Specialist providing services to homeless youth and only 30 beds of inpatient chemical dependency treatment available for youth under age 18. Other resources for chemical dependency treatment are very scarce. Youth must wait months to get into treatment from the time they request it. The realities of street life and addiction prevent most from maintaining a commitment to attending treatment for extended periods of time. In the absence of easily accessible chemical dependency services, advocacy is required by other providers working with youth to connect them with resources and assist them in managing their lives with minimal services.

Case Management Needs of Youth and Young Adults in Seattle

As described above, many homeless young people are not eligible for housing programs because of chemical dependency, mental health issues and criminal histories. In addition to providing advocacy and support to youth in accessing services and coping without needed services, intensive case management services are also effective with many of these youth in reducing the negative impacts of life on the street, completing their education, obtaining jobs or public benefits and moving off the streets into shared or independent housing. Seattle currently has 20 case managers serving about 500 youth. This leaves a gap of 150 youth who are not able to access case management services²³.

Outreach and Engagement Needs of Youth and Young Adults in Seattle

²¹ City of Seattle Human Services Department (2000). Homeless Youth in Seattle/King County: Service Gaps Analysis. Seattle, WA.

²² Paradise, M. & Cauce, A.M. (2003). Substance Use and Delinquency During Adolescence: A Prospective Look at an AT-Risk Sample. Substance use & Misuse, 38, Nos. 3-6: 701-723.

Greene, J.M. & Ringwalt, C.L. (1997). Substance Use Among Runaway and Homeless Youth In Three National Samples. American Journal of Public Health 87(2), 229-236. continued...

(note 16 cont.) Robertson, M., Koegel, P. and Ferguson, L. (1989). Alcohol Use and Abuse Among Homeless Adolescents in Hollywood. Contemporary Drug Problems, 16, 415-452.

²³ City of Seattle Human Services Department (2000). Homeless Youth in Seattle/King County: Service Gaps Analysis. Seattle, WA.

Outreach serves two purposes in the homeless youth population: information and engagement. In order for youth and young adults to access services they must know what services are available and how to use them. Most young people have limited experience in seeking services, therefore homeless youth find it difficult to get accurate information about services. Some youth are reluctant to become involved in services because of previous bad experiences and/or unfavorable comments about services they might hear from others on the street. Outreach workers can meet youth where they congregate, provide accurate information, transportation to service sites, and develop trust by demonstrating a genuine interest in helping and ability to provide useful resources. Drop-in Centers provide low-barrier access to basic needs enabling workers to engage youth in transitional services.

Summary of Housing and Service Gaps

Homeless Youth and Young Adults Need: Gaps Chart			
	Estimated Need	Current Capacity	Unmet Needs/Gap
Youth Shelter	20 ²⁴	3 beds	17 beds
Youth Transitional Housing	90	35 beds	55 beds
Young Adult Shelter	60	33 beds	27 beds
Young Adult Transitional Housing	130	71 beds	59 beds
Young Parent Transitional Housing	70	16 beds	54 beds
Case Management ²⁵	650	20 case managers 500 youth	12 case managers 150 youth
Mental Health Services ²⁶	160	1 PT Psych., 1 MHS 45 youth	6 MH Specialists 115 youth
Chemical Dependency Treatment ²⁷	160	1 CD Spec. 25 youth 30 <18 beds	5 CD Specialists 135 youth 26 young adult treatment beds
Outreach/drop in ²⁸	640	Three street outreach teams based at drop-in centers	New outreach strategies needed to reach youth of color. Mobile van outreach needs to be restored.

Source: City of Seattle Human Service Department 2000

²⁴ Estimated demand for all types of shelter/transitional housing calculated by subtracting the % of total homeless youth/young adult population who may be served in adult programs, moved into permanent housing without using shelter/transitional housing, or unable/unwilling to use such programs.

²⁵ This number refers to the number of youth not in a transitional housing program. It does not include case management provided by transitional housing programs.

²⁶ The numbers for Mental Health, Drug/Alcohol and Dual Diagnoses services represent expected demand, if services are appropriate and easily accessible to homeless youth. Expectations are that 20% of the total population (800) would use Mental Health Services, 20% would use Drug/Alcohol Services and 20% would use a combination of the two services (Dual Diagnoses).

²⁷ The numbers for Mental Health, Drug/Alcohol and Dual Diagnoses services represent expected demand, if services are appropriate and easily accessible to homeless youth. Expectations are that 20% of the total population (800) would use Mental Health Services, 20% would use Drug/Alcohol Services and 20% would use a combination of the two services (Dual Diagnoses).

²⁸ Average number in service through Drop In Centers at any one time. Number of centers is adequate, additional services are needed but are described under "Case Management," "Mental Health Services," and "Drug/Alcohol Services." Number currently served by outreach plus estimated number of known undercounted groups.

Gaps Analysis Chart

The methodology for determining the unmet needs or gaps in services in the above chart is included in footnotes. This methodology is based on a homeless youth and young adults community planning process conducted in 2000 and updated annually since then. The above chart provides greater detail and reflects more in-depth planning for this special needs population of youth and young adults than the data prepared for all homeless populations for the Continuum of Care Plan. As a result, these gaps estimate are higher than those shown in the Continuum of Care Plan.

Service Strategy

Seattle has worked to develop a comprehensive continuum of care for homeless youth and young adults that starts with prevention efforts, includes outreach and emergency services to meet basic needs, and ultimately leads to permanent, stable, affordable housing. The City has worked with youth, providers and other systems, including mental health and chemical dependency agencies, to continually develop more comprehensive and effective services for homeless youth and those at risk of homelessness. Resources in many needed areas still fall far short of the demand, and the City has worked to develop capacity through coordinated, outreach-based case management services, to bridge the gap for young people so they remain safer, healthier, and better prepared to take advantage of services and housing opportunities when they become available. Homeless youth services programs provide creative outreach, case management, emergency shelter, referral and support to assure that homeless youth and young adults access the necessary level and types of service to effectively transition off the street and into safe and stable housing and, at maturity, permanent housing. Neighborhood-based multi-service centers act as hubs for offering outreach, case management, meals, employment and training, GED classes, health care, substance abuse and mental health counseling, AIDS prevention and harm reduction services. Community Development Block Grant and Emergency Shelter Block Grant funded services play an important role in supporting emergency and transitional services in the continuum of care for youth and young adults that is primarily funded by the City General Fund and McKinney resources with significant assistance from the faith community.

PEOPLE WITH HIV/AIDS AND THEIR FAMILIES

Characteristics of the HIV/AIDS Population

According to Public Health – Seattle & King County, an estimated 8,400 individuals are living with HIV/AIDS in King County, with 400-500 new HIV infections occurring each year. The biggest increases in new infections are among people of color, women, young adults, and recent immigrants. Similar to most other areas of the country, HIV/AIDS has disproportionately affected African Americans/Blacks and Hispanics/Latinos.

An estimated 750 women are HIV-positive in King County, which includes women who have not been diagnosed and a small number who have tested positive but have not been reported. Women represent nine percent of the total HIV/AIDS cases, which has increased over recent years and is expected to continue increasing. The racial disparity is even greater among women compared to men. The rate is thirteen times higher for African American/Black women than White/Caucasian.

Other key facts for Seattle-King County include:

- An estimated 1,000 youth and young adults (ages 13-24) are HIV infected.
- Seventy percent of the people living with HIV/AIDS are men who have sex with men.
- An estimated 10 % of the HIV-infected residents of King County were born outside of the United States.

Critical Issues for People living with HIV/AIDS

Increasingly, people living with HIV/AIDS also have substance use or mental health issues that may or may not be combined with homelessness. People with both substance use issues and mental illness are at a greater risk for HIV/AIDS, are overrepresented in the homeless population, and experience more barriers to housing and health care. Substance use and homelessness are also closely associated with incarceration and involvement with the criminal justice system. Particularly as people with HIV/AIDS live longer lives, incarceration is a growing concern.

Appropriate services and housing for people with histories of homelessness, mental illness, substance use, and/or incarceration can make a critical difference in improving health and quality of life. For example, housing stability is often necessary for a person living with HIV/AIDS to gain access to health care and adhere to treatment regimens. Individuals who have had histories of substance use, mental illness, and homelessness often need ongoing support services in order to maintain stable housing.

People living with HIV/AIDS who have low incomes face the same challenges as other people with low incomes, and they frequently turn to the same resources to meet their housing and services needs. Clearly, people with disabilities who depend on SSI – equivalent to just 17 % of the median income for an individual in 2004 – have even fewer housing choices. The Fair Market Rent for a one bedroom apartment in Seattle is \$843 per month; \$279 more than the monthly SSI income of \$564.

Many individuals and families are forced to make critical choices when their income is not sufficient to meet their basic living needs. It may mean fewer meals, no health care, loss of utilities, overcrowded housing, or eviction. For people living with HIV/AIDS who have low incomes, these choices can have a serious effect on their health status.

Resources to Address Housing Needs for People living with HIV/AIDS

Seattle-King County has a well-developed continuum of AIDS-dedicated housing and services which has evolved over the last 10 years. It includes 106 independent and supported transitional housing units, 369 permanent independent units, 18 assisted living beds, and 35 skilled nursing beds. Developments for families are coming on-line in 2004 and 2005.

The priorities of the Housing Opportunities for Persons with AIDS program (HOPWA), administered by the City of Seattle Human Services Department, are to prevent homelessness and promote housing stability. HOPWA-funded programs serve more than 500 people per year in King and Snohomish Counties through rental assistance, permanent housing development, set-aside units, services enriched housing, adult day health, and assisted living.

Despite the resources available through the continuum, some notable gaps are emerging. Clients with personality disorders and other mental health issues are difficult to successfully house and require additional time and energy from case managers and service providers. There are few housing options available for individuals exiting the criminal justice system, or for those who have poor or no credit. People without legal status cannot be served by most of the housing programs that receive funding from HUD. Increasingly, new clients are presenting with language and cultural barriers that are difficult to address through the AIDS housing and service system.

Further, the existing AIDS housing inventory is prioritized for people disabled by AIDS with incomes below 50 percent of median. There are very few housing resources for low income people who are HIV positive and not disabled by AIDS.

The 2004 Seattle-King County HIV/AIDS Housing Plan, available in summer of 2004, will provide in-depth information on housing needs, gaps, barriers, critical issues, and recommendations.

Victims of Domestic Violence

Domestic violence is a widespread social and public health problem that affects not only the victims, the perpetrators, and their children, but the entire community. Each year, domestic violence impacts thousands of families in Seattle. In 2002, the Seattle Police Department responded to 12,483 domestic violence-related calls for service. However, national research suggests that the problem touches many more families than these data indicate. The National Violence Against Women Survey²⁹ found that nearly 25% of US women and 7% of men reported that they were raped and/or physically assaulted by a current or former spouse or partner at some time in their lives. Based on this research, it is estimated that approximately 66,000 female Seattle residents will be physically and/or sexually assaulted by their spouse or intimate partner at some point in their lives.

There is a broad consensus about the behavioral definition of domestic violence among researchers and service providers nationally and internationally. The American Bar Association³⁰ provides the following definition of domestic violence:

Domestic violence is a pattern of behavior that one intimate partner or spouse exerts over another as a means of control. Domestic violence may include physical violence, coercion, threats, intimidation, isolation, and emotional, sexual or economic abuse. Frequently, perpetrators use the children to manipulate victims: by harming or abducting the children; by threatening to harm or abduct the children; by forcing the children to participate in abuse of the victim; by using visitation as an occasion to harass or monitor victims; or by fighting protracted custody battles to punish victims. Perpetrators often invent complex rules about what victims or the children can or cannot do, and force victims to abide by these frequently changing rules.

Domestic violence is not defined solely by specific physical acts, but by a combination of psychological, social and familial factors. In some families, perpetrators of domestic violence may routinely beat their spouses until they require medical attention. In other families, the physical violence may have occurred in the past; perpetrators may currently exert power and control over their partners simply by looking at them a certain way or reminding them of prior episodes. In still other families, the violence may be sporadic, but may have the effect of controlling the abused partner.

Unlike other assailant-victim situations, the batterer has a deep personal knowledge of the victim's lifestyle, needs, and vulnerabilities, and may have unlimited access to the victim, and the victim's children, friends, and family members. This puts the victim at grave risk. She is often terrified of the batterer, and cannot speak openly about the violence because of her fear of a broad range of potential negative consequences. This fear is quite realistic and is based on her experience of the behavior and threats by the batterer. The consequences of disclosing the violence may include further violence by the batterer as "punishment," loss of custody of her children, further isolation from supportive friends and family members, loss of her home, loss of child support, loss of public

²⁹ National Violence Against Women Survey, U.S. Department of Justice, July 2000.

³⁰ When Will They Ever Learn? Educating to End Domestic Violence, A Law School Report: American Bar Association Commission on Domestic Violence, U.S. Department of Justice, Office of Justice Programs, 1997.

benefits, and other essential resources. This fear greatly enhances the batterer's ability to control and to abuse her.

When a woman leaves an abusive relationship, she often has nowhere to go. Across the United States there are now several hundred confidential shelters for victims of domestic violence. Because of the level of lethality, many victims have to flee their immediate jurisdiction and go to a confidential shelter in another county or state. 2002 data³¹ from the four confidential domestic violence shelters in King County reflect this pattern:

2002 Data- King County DV Data Base ³²	New Beginnings Shelter (Seattle)	Catherine Booth House Shelter (Seattle)	Eastside Domestic Violence Program (Bellevue)	Domestic Abuse Women's Network (Kent)	Total
New Intakes 2002	81	76	59	106	322

Residence at Intake- Seattle	42%	36%	29%	31%	
Residence at Intake- North KC	4%	1%	0%	3%	
Residence at Intake- South KC	19%	21%	26%	41%	
Residence at Intake- East KC	5%	3%	19%	9%	
WA State- out of KC	20%	27%	25%	10%	
Out of State	11%	12%	2%	6%	
	101%*	100%	101%*	100%	

*Totals more than 100% due to rounding

During 2002, for every domestic violence victim served by a local domestic violence shelter in King County, 11 other women were turned away.³³

Transitional housing for survivors of domestic violence is also limited. In Seattle there are only 47 units of transitional housing with specialized support services.

Many studies demonstrate the contribution of domestic violence to homelessness, particularly among families with children. A 1990 Ford Foundation study found that 50% of homeless women and

³¹ King County Domestic Violence Data Base

³² King County Domestic Violence Data Base

³³ King County Domestic Violence Coalition, 2004.

children were fleeing abuse.³⁴ In addition, 46% of cities surveyed by the U. S. Conference of Mayors identified domestic violence as a primary cause of homelessness.³⁵ In the City of Seattle, only 5 percent (or 79-81) of the facility-based emergency shelter beds are available for women with children.

Issues That Impact Homelessness of Victims of Domestic Violence

Safety – Shelter provides immediate safety to battered women and their children and help women gain control over their lives. The provision of safe emergency shelter is thus a necessary first step in meeting the needs of women fleeing domestic violence. To assure the ongoing safety of these women, the shelters should provide or facilitate access to services that help the women develop and implement safety plans.

Mental Health – Women who have experienced domestic violence also experience high levels of physical and mental health problems. For example, the Passaic County (New Jersey) study³⁶ found that 54% of the currently abused women stated that they were depressed and a similar study found the over 11% were suffering from acute depression. Mental health problems compound the difficulties the victims of domestic violence have with accessing and maintaining safe housing. Effective emergency and transitional housing for these women includes case management and access to services that help them establish stability

Employment – Recent studies (see footnote 28) document that abused women do seek employment but are not able to maintain it because of interference from intimate partners. This affects their ability to maintain housing over the long term. Program designs to support housing for abused women must include strategies to deal with abusers who interfere with her capability to hold a job, or participate in work-training programs, and thus afford stable housing over time. Mental health and other issues frequently make it difficult for survivor to actively seek work: according to 2002 data from the four confidential shelters in King County, an average of 30% were not in the job market and 23% were unable to work.

Financial and Housing Practices and Policies – An abusive partner creates barriers to securing affordable housing when he wreaks havoc on a battered women's credit history, leaves her with poor landlord references, and impedes access to the joint financial resources of the relationship for security or utility deposits.³⁷ The federal Department of Housing and Urban Development's "one strike policy" for eviction also creates a hardship for victims of abuse. In many parts of the country victims of domestic violence are being evicted if the police are called to their housing unit too many times (Griffin, 1999; Renzetti, 2001).³⁸ Solutions to many of these situations will involve legislative or regulatory action.

³⁴ Zorza, Joan, "Woman Battering: A Major Cause of Homelessness," in Clearinghouse Review, vol. 25, no. 4, 1991.

³⁵ U.S. Conference of Mayors, A Status Report on Hunger and Homelessness in America's Cities: 1998.

³⁶ Raphael, Jody and Tolman, Richard, Trapped in Poverty/Trapped in Abuse: New Evidence Documenting the Relationship Between Domestic Violence and Welfare.

³⁷ Correia, A. and Rubin J., Housing and Battered Women, Minnesota Center Against Violence and Abuse, 2004.

³⁸ Renzetti, C., "One strike and you're out": Implications of a federal crime control policy for battered women, Violence Against Women, 7 (6), 685-698.

Refugee and Immigrant Population Groups

According to the Brookings Institution Center on Urban and Metropolitan Policy: “At the turn of the 21st century, understanding the characteristics of growing foreign-born populations is central to understanding the social, economic, and political dynamics of cities.” Nationwide, the U.S. Census identified 31 million foreign-born persons representing approximately 11% of the total population living in the United States. This compares rather dramatically to the 1970 census which identified approximately 5% of the total population as foreign-born.

Seattle has been a portal of entry for thousands of refugees and immigrants in the past three decades. The city is also a popular destination for many secondary migrants attracted to its diverse cultural and social environment as well as the presence of family members who provide the needed social support conducive to their assimilation into U. S. life.

Seattle ranks in the top third of large U.S. cities with foreign-born populations. Of a total population of 563,374 in the city, 94,952 are foreign-born or one foreign-born resident for every six residents born in the United States. Seattle's foreign-born population grew from 67,736 in 1980 to 94,952 in 2000, a 40.2% increase.

Over half of Seattle's foreign-born residents or 44,334 persons have become naturalized U.S. citizens, the second highest among 23 largest cities in the Brookings Institution study. Approximately 55% of all immigrants are from Asian nations, although significant numbers have also arrived from Europe, Africa, and Latin America nations.

The state of Washington has the fourth largest number of refugees in the country, of which approximately 66% live in King County. The Refugee and Immigrant Assistance unit in the state Department of Social and Health Services estimates that approximately 80,000 refugees currently reside in the greater Seattle area. Southeast Asians comprise 48%, or the largest percentage, of the County's refugee population. However, a growing segment of this population is from East Africa, which represents about 13% of the refugee population. They include refugees from Ethiopia, Eritrea, Somalia, and Sudan. Eastern Europeans make up 31% of the refugee population in King County; however most are concentrated in south and east King County. Less than 10% of the refugee population is from the Middle East.

Refugee Populations in Seattle/King County		
Region of Origin	Number	Percent
SE Asia	35,196	48%
Eastern Europe	25,509	34%
Eastern Africa	9,291	13%
Middle/Near East	4,079	6%
Total	74,075	100%

Source: 2000 U.S. Census

The more stringent screening of foreign arrivals to the U.S. following 9/11 is reflected in the decreased number of refugees admitted for resettlement in recent years. The admission ceiling set by Congress for new refugee arrivals was radically reduced when it was dropped from 70,000 in 2001 to 27,000 in 2002. In 2001, only 27,180 were actually admitted. Refugee admissions increased dramatically when 20,529 were admitted during the first six months of 2003. Of this number, 31.5% were from the former Soviet Union, 31.9% were from Africa, 16.6% from the Near East, 6.9% from Asia, and 1.2% from Latin America.

2003 Refugee Arrivals in Seattle/King County		
Country of Origin	Number	Percent
Former USSR	766	72%
Iran	72	7%
Somalia	56	5%
Ethiopia/Eritrea	49	5%
Vietnam	33	3%
Liberia	20	2%
Bosnia	19	2%
Afghanistan	18	2%
Sudan	7	1%
Iraq	6	1%
China	1	0%
Total	1,058	100%

Source: Public Health-Seattle & King County, Refugee Screening Information, April 2004

Seattle-King County resettled 1,058 refugees in 2003 of which 72% were from the former Soviet Union; 2% from Bosnia; 13% from Ethiopia, Eritrea, Sudan, Somalia, Liberia; 10% from Afghanistan, Iran and Iraq; and 3% from Vietnam.

Welfare Profile of Refugee and Immigrant Communities

In the current tight labor market, there are refugees and immigrants who need assistance from government programs such as the Temporary Assistance for Needy Families (TANF) and the Refugee Cash and Medical Assistance (RCMA) programs.

Limited English Proficient (“LEP”) Adults on TANF or RCMA in Seattle/King County		
Language	Number receiving TANF	Number receiving RCMA
Russian	667	120
Somali	324	27
Vietnamese	216	3
Spanish	116	1
Cambodian	49	
Farsi	54	4
Laotian	13	4
Others	731	146
Total	2,170	301

Source: Department of Social and Health Services, Economic Services Administration, March 2004

Data from the State Department of Social and Health Services showed 2,170 refugee or immigrant households enrolled in TANF and 301 households in the federal RCMA in March 2004. Of those on TANF, 30% were Eastern European, followed by 15% Somali and 9% Vietnamese. Those on the RCMA program were predominantly Eastern European families (40%) followed by Somalis (9%). The state's ESL and employment training programs served 953 refugees in 2003.

Emergency Shelter and Publicly Assisted Housing

Though community nonprofit agencies which serve refugees and immigrants report that many refugees reside in public housing in Seattle, the local Housing Authority currently does not compile data on the number of refugees and immigrants on its waiting list or occupancy list.

However, the Annual One-Night Count in October 2003 conducted by the Seattle-King County Coalition for Homeless provides a snapshot on the number of refugees and immigrants who utilized emergency shelters or transitional housing units. The study concluded that, on any given night, approximately 9.9% of homeless persons are refugees or immigrants from Africa and 9.7% are Hispanic/Latino. The One Night Count of Hispanic/Latino persons may include undocumented immigrants. However, providers believe that the numbers recorded for this population group do not accurately reflect the actual number of Spanish speakers who are homeless on any given night. Agencies which serve primarily Spanish-speaking persons report that a large number of their clients are undocumented and do not go to emergency shelters because of apprehension about requests for documentation about their INS status.

These providers report that most Spanish-speaking homeless people do not like to go to places where they are not in the majority and instead prefer to sleep under bridges within clusters of homeless Latinos. Providers cite difficulties in finding affordable housing for large Latino families and the inability of these Spanish speakers to access other mainstream services because staff do not speak Spanish.

Agencies report that they are unable to serve increasing numbers of Spanish-speaking single men who need housing services. Many simply provide a hot meal at noon and referrals to hygiene and shelter services. One service provider suggests establishing a shelter for primarily Spanish-speaking persons.

The One Night Count found 707 refugees or immigrants utilizing shelter services or 19.6% of the total number of 3,595 persons in shelters. Of this number, 480 were new arrivals in the U.S. and 411 had limited English speaking capabilities. Languages spoken included Spanish, Somali and other African dialects and a few Asian dialects. It was noted that refugee families seeking shelter were comprised of many family members.

Being able to house large refugee or immigrant families, along with bilingual and culturally competent services, is an emerging need in the system of services for homeless people. Of refugees enrolled in TANF and RCMA programs, 51% have families of four or more persons. The "Needs and Gaps" section of the 2002 King County Refugee Service Delivery Plan identified transitional and permanent housing as a need, especially for large families.